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CLINICS.

Clinical Lecture on the Treatment of Stumps. By WM. FERGUSSON, Esq., Prof. of Surgery in King's College, London.

Gentlemen:—Having lately been engaged with the subject of amputation in my lectures at the college, I intend now, in accordance with the promise which I made on a recent occasion, to draw your attention to the mode of treating the wounds, which the surgeon, of necessity, makes in these operations,—a subject which can be more practically discussed in the hospital than in the theatre of the college. I have the greater satisfaction in finishing my lectures on amputation in this manner, as we have recently had a variety of opportunities of witnessing the practice which we are in the habit of pursuing in this institution in such cases.

A stump of the thigh gives a good example for illustrating the general principles of treatment, and having had three cases of the kind under observation since the beginning of the session, we may not possibly have a more favourable time than the pre-

sent, for the objects of such a lecture as that in which we are now engaged.

In former clinical lectures, I have alluded to the cases in question, but chiefly with the view of pointing out their histories, and the causes which seemed to render amputation necessary; and as you have now witnessed the treatment subsequently pursued in all of them, you have had opportunities of judging for yourselves as regards the results.

The cases were:—

I.—Sarah Crantz, æt. 18, congenital paralysis, and deformity of lower extremity. Amputation performed at her own desire. Operation on lower third of thigh, by double flap, anterior and posterior. Limb removed 8th October, 1844, at half-past one o'clock, P. M.; wound permanently dressed at eight in the evening.

October 13th.—Some of the dressings removed for the first time.

15th.—Dressings entirely renewed.

31st.—Wound completely cicatrized, excepting a small circumscribed spot.

II.—Morris Welch, æt. 42. Ulceration within knee-joint; hectic; October 12, 1844,

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at half-past one P. M.: double flap operation (anterior and posterior) six inches above joint: wound dressed in the evening.

Nov. 28th.—Stump entirely healed.

III.—Eliza Sanderson, æt. 27. Chronic ulceration of knee-joint, of ten years' duration.

Dec. 7th, 1844.—Limb removed, as in preceding cases. Wound dressed at the time of the operation.

18th.—Old dressing removed for the first time: wound ordered to be dressed daily afterwards.

January 1st.—Stump nearly well.

22d.—Walking about the ward in better health than she has enjoyed for years.

Although it is not customary to include the formation of the stump as a part of the treatment, (as it may be said that the treatment does not actually begin until the stump is formed by the process of severing the diseased part,) I am, nevertheless, inclined to consider that much connected with the results, as regards the qualities of a stump, depends upon the manner in which the operation is performed: and I, therefore, deem it the duty of the surgeon so to conduct his incisions, and so to fashion the soft parts, as to give himself the smallest possible amount of after-trouble, and ensure his patient as good a covering to the end of the bone, which must of necessity be divided, or exposed, during the operation, as the circumstances will permit. The common rules of practice are as much to be attended to here as under other conditions. Thus, when the surgeon has to remove a tumour which has caused great distension of the skin, he has to calculate how much of that tissue he must take away with the disease,—how much he must reserve, to permit the wound to be dealt with according to the common method of dressing, so as to procure immediate union. If the skin be much distended, he must take away a portion of it, else, were a single line of incision on the surface employed, there would be such loose folds as might endanger a collection of matter, for the surfaces could not be accurately laid in contact. On the other hand, were he to take away more skin than the circumstances demanded, he would be unable to bring the cut margins into contact, and so could not secure a speedy union. In either proceeding he would err, and the rule is to follow the medium course. A similar rule should guide the surgeon as to the amount of soft parts

which ought to be left in forming a stump: if he leaves the materials too long, the wound is unnecessarily large, and if they be too short, the end of the bone cannot be properly covered. He must steer the medium course here as well as under the circumstances alluded to above, and some consideration is required ere the knife is applied, as to the length and position of the incisions to be made.

It is the custom for some to give rules as to where the incision should be made, but there are so many things to be taken into consideration in each individual case, that I should not recommend you to trust entirely to such rules. I stated when I was showing these operations on the subject that I trusted to my eye chiefly in determining the length of the soft parts intended to form the stump. These are made in proportion to the thickness of the limb, but in one instance it may be requisite to have them much longer than in another, for in certain cases the elasticity of the parts, as well as the natural action of the muscles, will cause far greater contraction than in other examples. In a chronic affection, when the muscles have been long out of use, they will probably not retract or contract so much as when amputation is required immediately after compound fractures. As a general rule, it is well to leave the parts rather long than otherwise, for you will then have less trouble with the stump than if the parts were short. It ought to be borne in mind, however, that under any circumstances, and whether the stump be well or ill formed at first, its ultimate condition will depend greatly on the treatment pursued for weeks or months after the operation. The best cut stumps may turn out badly if the surgeon or his assistants be regardless of the after treatment, while even in cases where there has originally been some defect, much may be done by care to bring the parts into a creditable condition.

The mode of operation followed in the cases to which your attention has been directed, was that of the double flap, one from the anterior part of the limb, the other from the posterior. In such an operation it is of great consequence to keep the posterior flap considerably longer than the anterior. In front, the muscles and other soft parts retract but slightly, compared with those behind, where those muscles which pass from the pelvis to the leg, without taking any attachment to the femur, contract so greatly,

that unless they be left considerably longer than in the anterior incision, they will assuredly give the stump a very awkward appearance, by drawing the parts upwards and backwards, so as to cause the bone to appear very imperfectly covered by the tissues in front of the limb.

I am inclined then to consider, that it is as much the duty of the surgeon to look to the fashion of his incisions, before and during the time of his operation, as it is his custom with reference to other operations, but this of course, forms only a small part of his duty on such occasions.

The attention of the operator, as soon as the limb is severed, is immediately given to the vessels. Whatever he may have done to stop the circulation in the limb, during the requisite incision, he has to look to the means of securing the vessels by a method more permanent than by the hand or tourniquet. The main artery of the limb, and such others as are likely to bleed freely, must be secured with the thread, or in such other mode as the surgeon may choose. The ligature (for reasons which I have often explained to you before) is the method which I prefer to all others; it ought, in my opinion, always to be chosen before torsion; for, notwithstanding the high authority of Amussat and Fricke in favour of this practice, it possesses no such advantages as should supersede the ligature. In taking up the arteries I usually proceed thus:—I look for the known site of the main artery, and seize the vessel between the nails of my thumb and forefinger, or possibly I use the forceps—the ordinary dissecting forceps—and carefully separating the surrounding tissues, at the same time drawing the artery slightly out of its sheath, have it encircled by a ligature, which is fastened in the ordinary way with a double knot. For the smaller arteries I generally use the forceps: the end of the vessel lying between the blades is gently pulled out, and the assistant puts on the ligature as with the larger vessel. In the thigh below its middle, one ligature, or possibly three or four may suffice, but occasionally as many as a dozen may be requisite. I am in the habit of securing every vessel which conspicuously throws out arterial blood. It saves much trouble and pain afterwards, for such vessels are apt to bleed so freely after the patient has been put to bed, and has in some degree recovered from the shock which usually follows the opera-

tion, that it may become necessary to undo all the dressings, open up the raw surfaces so as to expose them again to the air, or to have more ligatures applied. I have never yet traced any serious results to the presence of a few additional ligatures, which possibly might not have been absolutely necessary; and the security, from their presence, amply compensates for any extra irritation which they may be supposed to cause. Sometimes a tenaculum is more serviceable than the forceps in laying hold of the arteries, or perhaps the hook-beaked forceps will be found useful.

The method of twisting the arteries (torsion) is such as I show you here (the method was exhibited on a stump in the dead subject): with a strong pair of forceps, whose blades can be kept closed with a catch, I seize the end of an artery, isolate it, and having drawn it from the sheath for half an inch or so, grasp it in a transverse direction with another pair of forceps similar to those first used, and then holding the vessel steady with the instrument last applied, I twist the end of the vessel round some four or six times, when on removing the forceps, the mass remains in the condition into which it has been thrown, the tunics having become so twisted and matted together that they do not become undone again. It must be evident that this process cannot be effected in all vessels, and I should consider it unwise to adopt it as a substitute for the ligature. (The usual methods of securing the arteries with the forceps and tenaculum were now mentioned and exhibited, and notice was taken of the kind of ligature generally used on such occasions.)

Bleeding from the veins may be somewhat copious, especially from the main vein in the upper third of the thigh, unless care be taken to apply pressure with the point of the finger; but very slight pressure in this way will suffice to restrain the flow until the wound is about to be closed, and when this is done the bleeding immediately ceases. A ligature is rarely required on such vessels.

The bleeding being arrested, the surgeon has then to close and dress the wound. Whilst attending to the vessels, he will have to use the sponge from time to time to wipe away the clots of blood, and in taking his last look at the surface, he will probably apply the sponge over it once more, so as to make it thoroughly clean. The ends of the ligatures are now to be laid where they can

be hung out of the wound, and I generally prefer putting them where they will have the most direct way to the surface. I place one by itself, or two or three together, as may seem most convenient, and commonly make a knot on the thread which surrounds the main artery, so that I may recognize it when it separates. The surfaces are now brought accurately together, and while an assistant gives careful support to the flaps, the surgeon secures their edges to each other by a series of stitches of the interrupted suture, four or six at least being requisite; and the spaces are accurately adjusted and the surfaces held together by means of straps of adhesive plaster. Next a piece of lint, dry, or wet with cold water, as you choose, or else spread with simple ointment, is laid along the track of the wound, and finally a roller is carried round the stump from above downwards; that is, from the pelvis along the thigh, so as to give support and steadiness to all. A few turns of the roller are made across the wound, these being suitably secured by several additional circular turns near the end of the stump, and so the dressing for the present may be deemed completed. (The process of dressing was here exhibited on the subject.)

On some occasions the propriety of closing the wound in the manner just described, may be questioned. From the continued oozing of blood from numerous small vessels, the surgeon may suspect that it will continue for a considerable time, and separate the surfaces, were he to close them. Under this impression, it is better to leave the wound open for a few hours until all bleeding has ceased, and this, as you will remember, was done in two of the cases under notice. But some surgeons always treat their stumps in this manner; they do not dress them till the lapse of six or eight hours after operation; at this time the blood having ceased to flow, and the surface being covered with an exudation of lymph, the parts are accurately laid together, and the dressing is conducted as it usually is at the time the patient is on the operating table. I think well of this practice in many instances, though as a general one, I prefer the mode of completing the first dressing as part of the operation.

Some difference of opinion still obtains as to the use of stitches in closing wounds. For my own part, the more I see of practice the more am I satisfied that they are to be preferred to all other modes. I have

never, on any single occasion, seen reason to attribute bad results to their use, and I have so far modified my own practice, that instead of cutting them out on the second or third day of their introduction, I allow them to remain for days longer, sometimes till the eighth or tenth; often till one end ulcerates out. It is only, however, when there is no evidence of their presence causing irritation that I do this, for if they seem to fret the parts I take them away immediately. The straps of plaster are so placed as to leave most of the stitches uncovered, so that when the next dressing is being attended to, you can deal with the stitches as may be deemed advisable.

After the first dressing, it is intended that nothing further shall be done for the next two or three days; but an important feature of treatment must be attended to during the interval, and this has reference to the position of the stump. The limb should always be so laid as to obviate any stress upon the surfaces where union is expected. In the thigh, for example, the part should be kept nearly on a level with the bed. Most patients desire to have the part bent upon the pelvis and so supported with pillows. In some the previous bent state of the limb predisposes to this attitude; but it is infinitely preferable that the end of the stump should be kept down, for if it be allowed to remain in an almost upright position, the weight of the soft parts is apt to endanger an exposure of the end of the bone, and much greater care in such a case is required in the application of a bandage in the after-treatment, than if the limb were kept horizontal.

If the patient has no particular uneasiness about the wound, it may be well to leave it till the third or fourth day: generally it is desirable to look at the part on one or other of these days: possibly this may be requisite on the second day, or you may not see reason for interference until some later date. However, when you do resolve to uncover the parts, you should have them soaked with moist warm cloths for several hours before you can undo the dressings. The moisture, thus applied, will permit them to be more readily separated. The bandage had better be cut, for you can remove it with less disturbance to the adhesions, than by attempting to unroll it. The roller and lint being removed, you will take away the straps or not as may seem necessary: if they

be not soiled, let them remain; and do not meddle with the stitches either, if this is the case. Put on a clean piece of lint, spread with unguentum cetacei, and cover all with a roller again, just as on the first occasion. Pay the same attention to position, and next day undo the roller, or cut it if you choose, and repeat the steps. On this occasion, however, it may be requisite to remove some of the straps, and put on fresh ones. You may also see the propriety of cutting away some of the stitches. Afterward the process of dressing every day must be repeated: and within the first three or four, all the stitches and original straps will probably be removed. By the tenth or fifteenth day, most, or all of the ligatures will have separated, and, if all goes on well, the sores and sinuses left behind them will close rapidly. A change of ointment, or from time to time, a new lotion, may be used with advantage, just as you would vary them in an ordinary ulcer:—and so the treatment comes to a satisfactory conclusion. Let me advise you to pay the utmost attention for many weeks after to the application of the bandage. The good quality of the stump depends greatly on the care bestowed on this part of the business. However well the stump may be formed originally, it may turn out badly in the end, if neglected in this respect. In the early stages of treatment the bandage need be but loosely applied,—just sufficiently tight to support the flaps, but latterly it may be used with more force, and the shape of the stump may be completely controlled by its judicious use. The treatment now described has been pursued in the cases which have been under your notice. Fortunately for the patients, every thing has gone on favourably, and you have not had an opportunity, as yet, of witnessing the casualties which happen, from time to time, in this department of surgical practice.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

National Convention.—The New York State Medical Society, at its last annual meeting, adopted resolutions recommending a "National Convention of Delegates from the Medical Societies and Colleges in the whole Union, to convene in New York on the first Tuesday in May, 1846, for the purpose of adopting some concerted action for

elevating the standard of Medical Education in the United States."

Ligature of the Subclavian Artery.—It is stated in the New Orleans Medical Journal, (July, 1845,) that this operation has been twice performed by Dr. A. MERCIER, of N. Orleans. The first operation was performed last year, for false aneurism of the axillary artery on the left side; the patient died from secondary hemorrhage. The second was performed on the 21st of June last, for aneurism of the subclavian itself, also on the left side. The case promises favourably.

Transylvania University and the Navy.—In an article published in a New York paper it was asserted as "a remarkable fact, that at the last examination of applicants for the appointment of Assistant Surgeons for the Navy, out of thirty examined, only sixteen were found qualified, and that the fourteen rejected as incompetent, were graduates of the Medical Colleges of Lexington, Ky., and Cincinnati, Ohio."

Though we cannot believe that such a statement will gain the least credence, still as those who have been thus slandered desire that their vindication should be published, we with pleasure insert the following letter from a member of the Naval Board to one of the Professors of the Transylvania School.

"PHILADELPHIA, April 21, 1845.

"Sir:—I have this day received your letter of the 15th inst., proposing the following queries, viz:

"How many candidates for examination for the place of Surgeon or Assistant Surgeon in the Navy, have you known, to have reported themselves as graduates of Transylvania University?"

"How many of the same have been found unqualified?"

"It gives me pleasure to state, in reply, that of the candidates for admission into the Medical Department of the Navy, rejected by the last Board of Naval Surgeons, not one was a graduate of either Lexington or Cincinnati; nor has any graduate of the Transylvania University yet presented himself before any Board of which I have been a member.

"I am, very respectfully, yours, &c.

"SAM'L BARRINGTON,

"Surgeon, U. S. Navy.

"To Thos. D. Mitchell, Prof. Mat. Med. and Therap., Transylvania University."

Laporte University, Indiana.—The number of students the last session was 45, of whom 6 received the degree of M. D.

Castleton Medical College.—The number of students at the spring session of this school was 136, and at the close on the 18th June, 35 received the degree of M. D.

FOREIGN INTELLIGENCE.

Injection employed by M. Payan, in Abscesses with Fetid Suppuration.—Ten grammes of Labarraque's liquid chloruret of soda, 200 grammes of water, mixed together. This injection is very useful to correct a vitiated condition of pus, and to prevent or remove the pernicious effects which it may produce on the system. Having employed it several times, says M. Payan, in cases of fetid suppuration, I have had occasion to congratulate myself on using it; it deprives the pus of its bad odour, as well as of its irritant and deleterious properties; the suppuration soon resumes its normal qualities, and the symptoms of fever, and even of purulent resorption, often disappear with a rapidity truly surprising, when the disease is not beyond the resources of art, either by its nature or by the previously existing lesions.—*Med. Times*, from *Bouchardat's Annuaire*, 1845.

Therapeutic application of the Ammoniacal Vapours.—Gaseous ammonia has long been employed in the treatment of certain chronic ophthalmias; the remedy used in such cases is a mixture disengaging ammonia, known by the name of *collyrium of Leayson*. Latterly M. Ducros has employed ammonia in nervous asthma and some other affections. The results that have been obtained have been greatly exaggerated among the non-professional public; the following is a very clear resumé which was given in the *Journal de Médecine*, published by M. Beau, with respect to the therapeutic application of the ammoniacal vapours:—

We especially recommend its use in the following cases:—Chronic laryngitis, with aphonia, a more or less complete extinction of the voice, all the chronic and subacute pharyngeal anginas, which frequently occur between the age of twenty-three to fifty in dartsous patients, or in scrofulous persons, subject to acute angina in their infancy or youth, as also in obstinate coryza of long standing; in nervous asthma, whatever may

be the degree of pulmonary emphysema which is present, and in spite of the existence of chronic, mucous, or pituitous catarrh; in certain chronic ophthalmias or conjunctivitis; and, finally, in simple or recent amaurosis. This measure, aided by the repeated application of blisters to the temple and superciliary region, appears to act in the same manner that they do, by stimulating the nervous expansions of the fifth pair of nerves, and produces advantageous effects in similar cases.

To fulfil these different indications, either in the preceding case, or in the diseases of the conjunctiva, of the mucous membrane of the nasal fossa, larynx, or bronchi, all that is requisite is to pass more or less rapidly before the half-opened eyes, or else under the nose and mouth at the moment of inspiration, an uncorked bottle, containing liquid ammonia, at from 20° to 30°, according to the necessity and indications of the case. In cases of asthma, the posterior paries of the pharynx may also be touched with a camel-hair pencil dipped in concentrated liquid ammonia.—*Ibid.*

Berengier's Pills for the cure of Incontinence of Urine.—Balsam of copaiba, hydrate of the peroxide of iron, each 3j; carbonate of magnesia a sufficient quantity. Make into pills of four grains each. From two to ten to be taken daily.

Chabreley's Pills against Incontinence of Urine.—Balsam of tolu, 3ij; storax balsam, 3iss; carbonate of magnesia a sufficient quantity. Make into 36 pills; six to be taken daily.

M. Bonjean on the poisonous effects of the Secale Cornutum.—The ergot of rye, taken as an alimentary substance, may give rise to two kinds of symptoms; to convulsive phenomena or to gangrene. These series of symptoms may present themselves singly or combined. A year ago, M. BONJEAN attended a family in the vicinity of Chambéry, all the members of which were attacked with the convulsive form; he has lately observed, in the same neighbourhood, a case in which the gangrenous form alone prevailed. A family composed of eight individuals—the father, mother, and six children, between the ages of two and seventeen—ate, during three weeks, bread containing one and a half per cent. of ergot. The father and

mother limbs: no abno est onl a boy bread d from the The fee with ph ing at the towards part of The oth attacked only. T toms w children Lyons, taken of cured.—

Solubilia.—Dica.—D is abund they may for the e are prod lour, wh tive prop so powerfects, wh to the pa strength tract ma which m sugar, a tion of h the gun in comb is partic it may b in chron —*Med.*

Fatal child eig suckling time wh citemen breast, t hunger child wa the who some ho other br in a ver stance

mother merely experienced lassitude in the limbs; the three eldest children presented no abnormal symptom. Two of the youngest only were attacked with gangrene: one, a boy, ten years of age, after eating the bread during fifteen days, felt a severe pain from the left groin to the calf of the leg. The feet and legs became tumefied, covered with phlyctenæ, and the gangrene, appearing at the inferior third of the legs, descended towards the feet, and ascended to the upper part of the legs, where it became limited. The other, aged twenty-eight months, was attacked in the same way, but on one leg only. There were no premonitory symptoms whatever in either case. The two children were admitted into the hospital at Lyons, where the gangrenous limbs were taken off, and they were subsequently quite cured.—*Lancet*, June 21, 1845.

Solubility of the extract of Cannabis Indica.—Dr. INGLIS says, as the pure extract is abundantly soluble in the essential oils, they may be used to form elegant vehicles for the exhibition of the gunjah. Solutions are produced of a bright emerald green colour, which, partaking of the soothing sedative properties of the gunjah, do not possess so powerfully its death-like depressing effects, which, for the time, are so alarming to the patient. They may be made of such strength, that a quarter of a grain of the extract may be exhibited in two drops of oil, which may then be rubbed up with a little sugar, and made into a draught by the addition of hot water. He has frequently given the gunjah internally, in a similar manner, in combination with cajeput oil, in which it is particularly soluble, and he has found that it may be used as a valuable embrocation, in chronic rheumatic affections of the joints.—*Med. Times*, May 10.

Fatal effects of the Mother's Milk upon a child eight months old.—A woman, who was suckling her child, gave it the breast, at a time when she was in a state of violent excitement. At first the child rejected the breast, but was subsequently compelled by hunger to take it. Soon afterwards, the child was seized with violent vomiting, and the whole of the milk was rejected. After some hours had elapsed, the child took the other breast,—convulsions supervened, and in a very short time, although medical assistance was at hand, and every attempt was

made to save it, it died.—*Lond. Med. Gaz.*, June, 1845, from *Casper's Wochenschrift*.

Use of the actual cautery in Arthritis following Parturition.—Dr. DOHERTY calls attention to the benefits capable of being derived from the employment of the actual cautery in combating the arthritic complications which occasionally attend that most dangerous form of puerperal fever where the veins become engorged. He has now seen five cases in which this destructive form of disease has been arrested by this remedy.—*Ibid.*, from *Dublin Hospital Gaz.*

On the colour of the Velum Palati in Icterus. By J. D. LONJON, D. M. P.—The colour of the mucous membranes in jaundice, with the exception of the conjunctiva, has been only generally alluded to by authors. I have observed the icteritious tint on all the mucous membranes except on the free border of the lips, and, I think, even here also. The colour, however, is less intense than that of the skin, and never of the greenish hue which this sometimes presents. This colour, which has been but vaguely alluded to by Portal, as existing in some cases of hepatic obstruction, merits, from its constant appearance, invariable seat, and form, some attention as a special sign of icterus. If the interior of the mouth be inspected, a yellow tint may be observed inside the lips, gums, inferior surface of the tongue, palatine arch, and lateral and posterior fauces. It need not be present in all these parts at one time, nor is it constantly found in any one of these situations. But on the velum palati, a yellow tint, constant, uniform, always deep, is spread over the surface of this region; posteriorly it is lost in the natural colour, more or less altered at the edge of the velum, uvula, and pillars of the fauces; but anteriorly it terminates by a well-marked transverse line, connecting the last molars of the upper jaw. If once seen, this sign will never be found to fail, even in the slightest cases; and in all stages it is decided and limited. I have also verified its presence in cases of lead colic, cancer of the liver and other organs, after intermittent fever, where the lengthened disease has imprinted on the skin a cachectic tinge peculiar to their respective natures. The only instance in which I failed to find it was the case of a man who, after comminuted fracture of the tibia, became jaundiced in some

parts of the face and conjunctiva, and after death, was found to have been the subject of two large hepatic abscesses. But its absence in this single instance must not be allowed to weaken its general value. Its presence in all, even the slightest cases of icterus, and also of pseudo-icterus, where the conjunctiva is rarely tinged, and its intensity, which is in proportion to that of the skin, claim for this sign some semiological value. It is of value especially when the other symptoms fail, or in cases where the natural colour of the skin prevents the morbid hue from being so readily recognized.

The rationale of this sign may be understood by reference to the anatomical characters of the part: the softness and excessive vascularity of the velum favour the icteritious effusion, which again becomes suddenly changed where this tissue is changed for the less vascular fibro-mucous tissue of the palatine arch.—*Ibid.*, from *Gaz. Médicale*.

Congestion of the Cerebellum.—Dr. C. BROUSSAIS, principal physician to the Military Hospital *de la Salpêtrière*, at Algiers, has just published a case in which the patient lost his equilibrium whenever he stood erect or walked, and which, after passing in review the different diseases with which it might be confounded, such as affections of the cerebellum, the medulla spinalis, neurosis, &c., he attributed to a lesion of the cerebellum; because the section or cauterization of that portion of the nervous centres causes, as the experiments of Messrs. Flour-ens and Bouillaud on pigeons prove, a loss of equilibrium, the birds tottering like a drunken person, as the latter so aptly remarks; because in a case in which he had attended with Dr. Magendie, the patient offered all the symptoms observed in the present instance, and at the autopsy, the cause was found to be a cancer of the cerebellum. Finally, as to the species of lesion, it was in all probability simple congestion, situated superficially, or in the membranes alone; may not these symptoms be explained by the difficulty with which the movements of the cerebro-spinal liquid are performed, owing to the congested state of the organ? It was for these reasons, that Dr. C. Broussais ordered venesection to be practised, and prescribed at the same time sulphas quininae, as the patient was affected with intermittent fever. *Case.*—G., ætat. 27, soldier; went to Africa three years and a half ago, strong

constitution; bilioso-sanguineous temperament; has since his arrival there, been affected with dysentery and intermittent fever; he suffers from tertian fever, and has already experienced two attacks. On his admission the 7th of March, 1845, and while M. Dumalle was auscultating his thorax—he being seated in his bed—he suddenly fell backwards, senseless; this state, however, was of very short duration, and G. was soon able to give the details just stated, to which he added, that he could neither walk nor stand erect for any length of time; no loss of sensibility nor motion; when requested to get up, he did so with perfect ease, but had hardly made two or three steps in the ward, ere his face became pale, his features contracted; he staggered and would have fallen had he not been supported. Taken back to bed, he was, after resting a while, made to sit up, but the same phenomenon took place as already mentioned; the heart presented nothing abnormal; pulsations beat 72 per minute; spleen not much enlarged; all the various functions appeared to be in their normal condition; from time to time the head became hotter than usual, as if the blood ascended in greater quantities. Venesection ad lbj; sulphat. quin., ʒj. The next day being that on which the fever ought to have taken place, the quinine was repeated; it did not, however, come on, and nine days after the patient left the hospital quite well.—*Med. Times*, from *Gazette des Hôpitaux*.

Sulphur in Bile.—M. REDTENBACHER has analyzed anew the *taurine* of M. Gmelin, and found that there was 26 per cent. of sulphur in it.

British Association for the advancement of Science.—The fifteenth meeting of this association was held at Cambridge during the week commencing Wednesday, June 18th. Sir J. Herschel, the president, delivered an interesting address. Next year the association is to meet at Southampton, in the month of September, the precise day to be hereafter fixed by the council.

DR. STOKES.—Dr. William Stokes has been appointed Regius Professor of Physic in the University of Dublin.

French Academy of Medicine.—M. LONGET has been elected a member in the section of anatomy and physiology.

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